ADULTS WITH SEVERE MENTAL ILLNESS

Criterion 1: Comprehensive Community Based Mental Health System

The plan provides for the establishment of a comprehensive, community-based system of mental health care for adults who have a severe mental illness, including case management, treatment, rehabilitation, employment, housing, educational, medical, dental, and other support services, which enables individuals to function in the community and reduces the rate of hospitalization.

Description of the Organization of the System of Care

The Kentucky Department for Mental Health and Mental Retardation Services (KDMHMRS) administers a comprehensive, community-based system of mental health care for adults with severe mental illness through contracts with Kentucky's Regional MH/MR Boards. KDMHMRS works with Kentucky Medicaid so that basic services, like outpatient and rehabilitation services, are available and have similar requirements for Medicaid and non-Medicaid eligible consumers.

To encourage the development by Regional MH/MR Boards of a full array of clinical, rehabilitation, and support services for adults with severe mental illness within their regions, KDMHMRS uses two strategies within its budgeting process. These strategies are:

- Priority Populations
- Community Support Services

Priority Populations

Since 1985, KDMHMRS has required Regional MH/MR Boards to prioritize certain populations, including adults with severe mental illnesses, in their budgeting processes. Despite budget deficits and competing priorities among the various program areas and service initiatives, funding levels for adults with severe mental illness have been maintained. As new funds have become available, further development of an array of community-based services has occurred. In addition, sub-populations who are historically under or inappropriately served have been prioritized including adults with severe mental illnesses who:

- Have co-occurring disorders
- Are homeless
- Are deaf or hard of hearing
- Are elderly
- Are of African-American descent

Community Support Services

To effectively meet the needs of adults with severe mental illness, KDMHMRS has worked with consumers and other stakeholders to identify and fund an ideal array of services that support adults with severe mental illness in the community. These service components include:

- consumer and family support
- crisis services
- housing options
- case management services
- mental health treatment
- rehabilitation services

These are collectively called "Community Support Services." These services extend the statutory and Medicaid-covered services of Regional MH/MR Boards.

KDMHMRS convenes quarterly statewide meetings of directors of local Community Support Programs to share information and new strategies, and to learn how the Department can support regional program initiatives.

The narrative provided for Criterion One describes key elements of the comprehensive Community Support Services array, and presents state level objectives for the coming year for their continued development. A list of Community Support Services in the ideal array and a representation of their current availability by region are shown in the following table:

Regional Availability of Community Support Services/2004

	Region													
Community Support Component	1	2	3	4	5	6	7	8	9/ 10	11	12	13	14	15
Consumer and Family Support														
Training and Advocacy		X	X		X		X				X		X	X
Consumer Support Group	X		X		X	X	X	X		X	X	X	X	X
Consumer Operated Social-Club Drop-In	x		x		X		X				X	X		
Local NAMI of Kentucky	X	X	X		X	X	X		X			X		X
Consumer Conferences	X		X		X			X		X	X	X		X
Peer Advocates/Crisis Response			X	X		X	X				X		X	X
Crisis Services														
Emergency-Help Line	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Walk-In Crisis Services (8-5,M-F)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Mobile Crisis Services			X	X			X	X	X					
Residential Crisis Stabilization	X		X	X	X	X			X	X	X			X
Mental Health Treatment														
Medication Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Community Medications Support	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Outpatient Therapy	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Intensive Outpatient	X	X	X		X									
Inpatient Treatment	X		X	X	X	X			X	X				X

Specialize Co-Occurring Disorders Services	X				X	X			X			X	X	X
Case Management Services														
Case Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Wraparound Funds	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Specialized Int. Case Management		X					X				X			X
Assertive Community Treatment							X				X			
Continuity of Care & Specialized Initiatives		X		X		X		X			X			
Homeless Outreach	X					X				X	X		X	X
Payee Services		X	X			X	X	X			X			X
Rehabilitation Services														
Therapeutic Rehabilitation	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Supported Employment		X	X			X	X		X	X		X		X
Educational Services			X				X	X			X		X	X
Other Community Support			X				X				X			
Housing Options														
Supported Housing			X	X		X	X				X			X
Residential Support			X		X	X	X	X		X	X	X		X
Housing Development		X				X	X	X	X	X	X		X	X

Consumer and Family Support

Introduction

Since its formation in the mid-1980s, KDMHMRS has been committed to consumer and family involvement in program development and service delivery as a strategy for strengthening informal community supports. Over the years, consumers and family members have become more active in assisting Department staff in developing policies, monitoring and providing technical assistance to local programs, and evaluating requests for funding to establish new services. Family members have been particularly effective in providing peer-to-peer outreach and education to other family members.

State Support

The Department provides funds for a variety of statewide and local consumer or family support initiatives. Each has unique goals related to advocacy, research, stigma reduction, peer support, education and training, operating support, and statewide coordination.

A Consumer Advocacy unit within the Division of Mental Health was established in 1993 to represent the consumer perspective in the development of Department policy and to coordinate consumer relations. Currently vacant after the resignation of the original advocate in December 2000, the Office has been elevated from the Division of Mental Health to a position of special staff advisor to the Commissioner of KDMHMRS.

The staff of the **Office of Consumer Advocacy** will continue to have primary responsibility to advocate at the state level on behalf of consumers of mental health

services in the public sector, in addition to advising the Commissioner on issues affecting consumers. Key functions of the office include:

- Program planning and evaluation;
- Training and education;
- Policy analysis and development; and
- Community organization and advocacy

During SFY 04, the Office of Consumer Advocacy (OCA) will focus on continuing a successful consumer Leadership Training Institute that was begun in March, 2003. The Institute is a partnership with the Commonground Training and Resource Center. OCA will also collaborate with the Kentucky Consumer Advocacy Network (KY CAN) in coordinating a new peer-to-peer review process of Regional MH/MR Boards during SFY 04.

The **Consumer Advocacy Committee**, established in 1994 to advise the Consumer Advocate on short and long-term goals, continues to convene at least quarterly and is comprised of consumers, family members, service providers, staff and other interested individuals. A consumer of mental health services volunteers to serve as the chair. To support the Office of Consumer Advocacy in strengthening links between statewide consumer-oriented projects, a steering committee is being created and will meet quarterly. The committee will be comprised of:

- Chair, Consumer Advocacy Council
- Director, The Recovery Network
- Director, KY CAN
- Director, NAMI KY
- Director, Commonground Training Center
- Representative of Regional MH/MR Board CSP directors
- Representative of Regional Board Therapeutic Rehabilitation program directors
- Representative of the Peer Support Programs
- Director, DMH.

The **Commonground Training and Resource Center (CTC)**, a joint project of the Department, the Kentucky Consumer Advocate Network (KY CAN), and NAMI Kentucky, is a policy and education center staffed by mental health consumers and designed for statewide training, information dissemination and technical assistance. During this year emphasis will be placed on education and training, particularly in the area of the development of consumer leadership within their local communities, and peer to peer review development and training.

The Commonground Training Center staff, in conjunction with KY CAN, NAMI KY, and the Office of Consumer Advocacy, will continue to reassess training goals and coordinate the development of curriculum used in that training. In addition, staff will help develop computer information networks with statewide programs, and assist consumer and family members with access to technology.

Services for the Deaf and Hard of Hearing

KDMHMRS employs a Statewide Coordinator for services to the deaf or hard of hearing. This position, in place since 1994, oversees all efforts to improve services for this population. In September 2002, a Program Coordinator was hired to work closely with the Statewide Coordinator. In response to the special accessibility problems of consumers who are deaf or hard of hearing, an Advisory Committee for Mental Health Services for the Deaf and Hard of Hearing was established by KRS 210.031 in 1992. Meeting on a quarterly basis and supported by these staff members, the advisory committee implements and monitors a variety of statewide and local consumer initiatives.

The challenge to KDMHMRS to improve services to persons who are deaf or hard of hearing is contained in a report, "New Directions for Mental Health and Deafness," prepared in June 1998 by consultants to the Advisory Committee and KDMHMRS. The report estimates that approximately 200 adults with severe mental illness, and 90 children with severe emotional disturbances, are deaf and will seek mental health services during a year. The recommendations include:

- Establish regional children's mental health services, serving deaf and hard of hearing children throughout the state.
- Establish a residential treatment program for deaf children at the Kentucky School for the Deaf, staffed with professionals who are sign-fluent and culturally competent to work with deaf children and their families.
- Establish regional teams consisting of a therapist, a case manager and an interpreter which provide culturally appropriately specialized services to deaf and hard of hearing consumers.
- Establish a single psychiatric/substance abuse inpatient unit within an existing treatment program, with staff members who are sign-fluent and culturally competent to work with this population. Ideally, services to both children and adults should be available on the same campus, to maximize professional resources.
- Develop accessible housing options for deaf consumers which are both physically accessible as well as culturally appropriate. Support staff in such programs should be trained in deafness and sign communication systems.
- Provide funds to the Psychology training program at Eastern Kentucky University to increase the scholarship offerings available to students training to become mental health service providers in deafness. Such training monies could be limited such that a recipient would be obligated to work in Kentucky after graduation.

The Department, the Regional MH/MR Boards, and the Legislature are responding to the challenge of the report. TTY and TDD devices have been installed in critical service sites throughout the state, including community mental health centers, state facilities and toll-free crisis lines. Individuals who are knowledgeable in deafness and mental health issues staff a statewide TTY Crisis Line. In addition to the providers, KDMHMRS staff has also received training in their use and in deaf awareness. Limited funds have been made available for interpreters, training and

equipment to make local treatment more accessible. Interpreters are routinely available to facilitate the participation of consumers who are deaf or hard of hearing in meetings and conferences.

Kentucky Guidelines for Services for Deaf and Hard of Hearing, Late Deafened, and Deaf Blind People has been disseminated to all fourteen Regional MH/MR Boards; Rape Crisis Centers, domestic violence staff and substance abuse staff. The Guidelines have been revised and retitled "Kentucky Standards of Care for Deaf and Hard of Hearing, Late Deafened and Deaf Blind People". The revised Standards of Care will be disseminated to all mental health service providers.

Regional Roll-Up

A review of the information from the SFY 04 regional plan applications reveals that:

- Nine regions sponsor consumer support groups;
- Six regions sponsor social-club drop-in programs;
- Nine have active NAMI affiliates;
- Nine sponsor consumer conferences;
- Nine report having designated staff positions for consumer and family members; and
- Five offer specialized mental health services for deaf and hard of hearing individuals.

Trends/Challenges

While KDMHMRS and the Regional Boards have come a long way in fostering consumer and family member participation in planning, monitoring, and service delivery, a number of challenges remain. These include:

- No dedicated funding source for consumer run services;
- Few programs incorporate recovery principles;
- Perception of risk in hiring consumers;
- Limited number of consumer run services that can serve as "mentor" programs; and
- Persistent transportation barriers to attending meetings and other events.

Strategies

KDMHMRS and the Regional Boards use a number of strategies to support consumer and family involvement. While funds are limited, a significant amount of block grant funding supports the operations of the statewide consumer organization, Kentucky Consumer Advocacy Network, and the statewide family organization, NAMI Kentucky. Additional strategies include:

- Encouraging increased collaboration between Regional Boards and Ky CAN and NAMI-Kentucky in sponsoring "Bridges" and "Family-to-Family" support groups;

- Providing reimbursement for consumer and family members to attend state level meetings, conferences and other gatherings; and
- Requiring that regional planning councils review plans submitted to KDMHMRS regarding block grant funds.

Performance Indicators

While no performance indicators are currently in place to measure consumer and family support, several indicators are being studied for inclusion in future plans. These include using specific questions from the MHSIP consumer survey as a measure of consumer perception of care. Other possible measures include:

- Counting the number of consumers and family members serving on Boards, primary committees, and other planning bodies;
- Counting the number of consumer run or operated services; and
- Counting the number of new consumer leaders trained through the Leadership Training Institute.

Objectives

It is anticipated that in SFY 04, Regional MH/MR Boards will continue to develop their growing array of consumer and family support services. Regional MH/MR Boards submitted the following plans in this area:

Region	Plan
1	Provide staff support through the CCSP to help consumers plan and expedite a conference for FY 2004.
2	Provide Family-to-Family education training series in two counties this FY.
3	Get SPMI case managers trained by Voc Rehab.
4	Peer support will be available in one additional county.
5	Will increase recruitment of consumer and family member representation to at least 51% of membership on Regional Planning Council.
6	Will provide location and support for Bridges meeting in at least one location.
7	The CSP Coordinator or her designee will initiate quarterly meetings with staff of Recovery Network of Northern Kentucky in order to foster collaboration in our community support services. A representative from the Consumer Advisory Group at NorthKey will meet with the TRP consumers (at Garden House and Our Place one time; and at Sunshine House and Focus House two times) this next year to share information from the bimonthly meetings and to elicit input for future meetings.
8	Participants in each of Comprehend's five Therapeutic Rehabilitation programs will attend at least one consumer conference in FY 2004.
9/10	Begin plan to develop warn line (see regional planning council comments).
11	20% increase in reported client self-esteem utilizing the MHSIP client satisfaction survey. Utilize the Multnomah Community Ability Scale to report increased ability function in the community. Due to funding restrictions and transportation cost, MCCC is unable to convert one TRP to a client-run drop-in center at this time. This may continue to be a goal, but not feasible at this time.
12	During FY 2004, KRCC will research new funding sources to determine if additional resources are available for consumer and family advocacy.
13	Continue to support the efforts of the two self help groups initiated in FY 03. Develop, train,

	consumers in peer advocacy. This will be accomplished by developing one pilot program in Catchment A and one pilot program in Catchment B by June 30, 2004.
14	Maintain employment of FTE Peer Support Coordinator.
15	Maintain enrollment of consumers and family members at 300 for Consumer Conference.

- **Objective A-1-1: Contingent on the receipt of new funding, hire and maintain one additional Master's level therapist specializing in deafness on staff of Regional MH/MR Boards in order to provide culturally competent mental health services to deaf and hard of hearing Kentuckians.**

- **Objective A-1-2: Contingent on the receipt of new funding, hire and maintain four case managers specializing in deafness and four interpreters to provide culturally competent mental health services to deaf and hard of hearing Kentuckians.**

- **Objective A-1-3: Contingent on the receipt of new funding, provide funds to the Psychology training program at Eastern Kentucky University to increase the scholarship offerings available to students training to become mental health service providers in deafness.**

- **Objective A-1-4: Sponsor Consumer Leadership Training Academy during SFY 04.**

- **Objective A-1-5: Institute new Peer-to-Peer Review process during SFY 04.**

- **Objective A-1-6*:* Prepare biennium budget request to fund one full-time Regional Peer Support Coordinator and five half-time Peer Support Workers in six of the mental health center regions. In addition, fund one full-time statewide Peer Support Program Administrator.**

Mental Health Treatment Services

Introduction

The Department funds Regional MH/MR Boards to provide an array of mental health treatment services, including outpatient services (i.e. individual and group therapy) to non-Medicaid individuals with mental illness.

State Support

In addition to funding an array of outpatient services, additional treatment programs include the following:

<u>Community Medication Support Program</u>

The Community Medication Support Program (CMSP) is a drug replacement program that provides low cost medications to the population who are living at a standard below poverty level and who do not otherwise qualify for federal or state

assistance. The previous success of this program is the result of a unique collaborative effort by the state operated/contracted psychiatric hospitals, the Regional MH/MR Boards, KDMHMRS, and local pharmacies. The goal of the program is to assist adults in the community with a severe mental illness who have no other means of purchasing prescribed psychotropic medication. Prescriptions are filled at local pharmacies, then the medications are replaced to the pharmacies by our state operated/contracted hospitals. The program is available in all regions.

Eligibility for the CMSP is based on age (18+), income (federal HHS poverty guidelines and no third party payer sources), and KDMHMRS criteria of severe mental illness (diagnosis, disability and duration).

Prescription drug costs are now recognized as a major factor in overall health care costs and premium increases. The past couple of years have yielded concrete information about the short and long-term effects of cost control strategies being applied to the pharmacy benefit. Currently, psychotropic medications represent the largest total drug cost increase by therapeutic category. KDMHMRS is reviewing the current CMSP process as spiraling prescription drug costs and antiquated procurement methods have made it increasingly difficult for uninsured mental health consumers to secure necessary medications.

Challenges for SFY 04 include accessing information related to what medications are most appropriate and effective for treating individuals with severe mental illnesses; examining and encouraging prescribing practices that are in accordance with evidence based practices; and determining who is best able to reasonably procure needed medications that maximize the limited allocations for the program.

Crisis Stabilization Services

Beginning in 1995, KDMHMRS has made a concerted effort to develop a statewide network of Crisis Stabilization Programs. These programs, which primarily serve individuals with serious mental illness, can be home-based interventions or residential units and are a major factor in Kentucky's reduction of inpatient utilization. In SFY 04, funding has been allocated to complete the statewide network by having a Crisis Stabilization Program in each Regional MH/MR Board service area.

The KDMHMRS Crisis Stabilization Coordinator supports the ongoing development and enhancement of the network by facilitating periodic meetings of Crisis Stabilization Program Director meetings and training events.

Regional Roll-Up

A review of the information from the SFY 04 regional plan applications reveals that all treatment services except partial hospitalization (which is not currently covered by Medicaid or KDMHMRS) are available in each region. Additionally it is reported that:

- Fourteen regions have a system of following up missed outpatient or doctor appointments for persons with severe mental illness;

- Seven regions have clinical practice guidelines in effect for individuals with mental illnesses;
- Five regions provide intensive outpatient services for individuals with mental illnesses;
- All fourteen regions have established strategies for dealing with individuals with co-occurring disorders; and
- Six regions have established specialized groups for individuals with co-occurring disorders.

Trends/Challenges

Budget constraints have forced some regions to scale back availability of mental health treatment services in less populous, rural counties. Additional challenges include:

- While all regions report having a system for following up with missed appointments, most recognize the need to provide assertive outreach so fewer appointments are missed.
- A shortage of professional staff, especially psychiatrists, have caused waiting periods for appointments to continue to grow.
- Continuity of care with inpatient settings and other community providers continues to be a major challenge in providing quality, holistic care.

Strategies

In addition to providing funding, KDMHMRS and the Regional Boards use the following strategies to insure that mental health treatment services are available as consistently as possible across Kentucky's fourteen mental health regions:

- Supporting the use of new assessment software applications such as LOCUS to insure consistent assessment of levels of care;
- Promoting the use of evidence-based treatment guidelines such as medication algorithms and dialectical behavior therapy;
- Recruiting of Advanced Registered Nurse Practitioners (ARNPs) who can prescribe medications in association with a psychiatrist;
- Establishing standards for insuring continuity of care across treatment settings.

Objectives

Regional MH/MR Boards submitted the following plans in the area of **treatment services:**

Region	Plan
1	Continue to assist consumers in accessing medications through options beyond the Community Medication Program, which is usually exhausted by mid Fiscal Year.
2	Focus: Medication management – Case Managers follow-up 100% missed appointments when notified by the psychiatric nurse of the missed appointment.

3	Cross train six therapists in co-occurring disorders.
4	Continue FY 2003 initiative to cross-train clinicians for dual diagnosis treatment.
5	Will initiate a call/contact system insuring that an SMI missed appointment call is made within 48 hours.
6	Specialized services for co-occurring disorders will be developed/expanded at each site.
7	During the next year pamphlets/flyers will be created and printed to give clients/families to explain case management, therapeutic rehabilitation, and crisis stabilization services. A work team will be formed comprised of at least a case manager, a clinician, and the CSP coordinator to determine what system of follow-up is needed for SMI clients who have dropped out of treatment without notifying any staff as to the reason for stopping services. This team will meet at least twice this year and make a clinical procedures policy proposal.
8	Maintain current outpatient treatment staffing patterns.
9/10	Identify a staff person who will receive training on co-occurring disorders.
11	Implement cross-training for at least 50% of CSP staff to work effectively with dually diagnosed clients by January 1, 2004
12	Research and apply for special funding from SAMHSA for a dual diagnosis program to serve persons with diagnoses of substance abuse and severe mental illness.

13	The agency will continue to cross train clinicians in co-occurring illnesses. This will be accomplished by conducting three trainings by June 30, 2004.
14	Continue with assisting clients to obtain medications through indigent programs of pharmaceutical companies and CMSP (when criteria is met). Maintain current level of care.
15	90% of Case Managers will receive specialized dual diagnosis training during the fiscal year.

- **Objective A-1-7: Research alternative processes to manage existing resources within the Community Medications Support Program.**

- **Objective A-1-8: Expand the availability of crisis stabilization services to all fourteen regions by the end of SFY 04.**

- **Objective A-1-9: Assist Regional MH/MR Boards in implementing crisis stabilization programs through statewide technical assistance meetings to be held a minimum of three times per year**

Efforts To Reduce Psychiatric Hospitalization

Introduction

KDMHMRS strategies to reduce unnecessary psychiatric inpatient utilization include the development of residential crisis stabilization programs and the continued development of other community support services as effective alternatives for adults with severe mental illness who are in crisis. These strategies have been discussed in the preceding sections. This section discusses the reduction in the use of hospitals by adults.

State Support

Olmstead Initiative

KDMHMRS has responsibility for the monitoring of this initiative in each of the four state operated/contracted psychiatric hospitals. Transition teams comprised of the representatives from the hospital, the Regional MHMR Board, KDMHMRS staff, and other appropriate stakeholders meet on a frequent basis to review transition plans that assure a smooth and timely discharge to the community for identified patients. Funds were appropriated during the 2002 legislative session to pay for individualized and specialized wraparound services to assure the community tenure for each of these individuals.

Privatization Initiatives

In 1995, KDMHMRS entered into an agreement with Bluegrass Regional MH/MR Board to operate Eastern State Hospital, a 251 bed psychiatric facility which serves fifty counties. While no major change in utilization occurred (census remains at half the capacity), savings have been realized and shifted to community services. During SFY 97, the privatization resulted in $2.6 million in savings, which was redirected to the five Regional MH/MR Boards served by Eastern State Hospital.

At Central and Western State Hospitals, privatization has taken the form of augmenting the staffing complement by contracting with a Regional MH/MR Board for additional staff and by contracting out particular functions.

State Psychiatric Hospitals

Kentucky has reduced its state hospital beds by more than 90 percent from the 7,689 beds available in 1955. From SFY 95 through SFY 98 the average daily census decreased by 20% at the four non-forensic state-supported psychiatric hospitals. The charts on the following page display changes in average daily census and average length of stay in state psychiatric hospitals. Kentucky state hospital services are limited to adults.

Regional Roll-Up

No roll-up information was required from the Regional MH/MR Boards in their applications.

Trends/Challenges

An alarming trend is the conversion of private psychiatric beds to acute care beds in private psychiatric hospitals. Even though the total number of conversions during the last year has not reduced the overall supply to an amount less than the estimated need (according to the Office of Certificate of Need), it has created pockets in the state where individuals must travel greater distances to obtain inpatient psychiatric care. For some Regional MH/MR Boards, it remains a difficult task to develop workable memorandums of understanding concerning continuity of care between inpatient and outpatient settings.

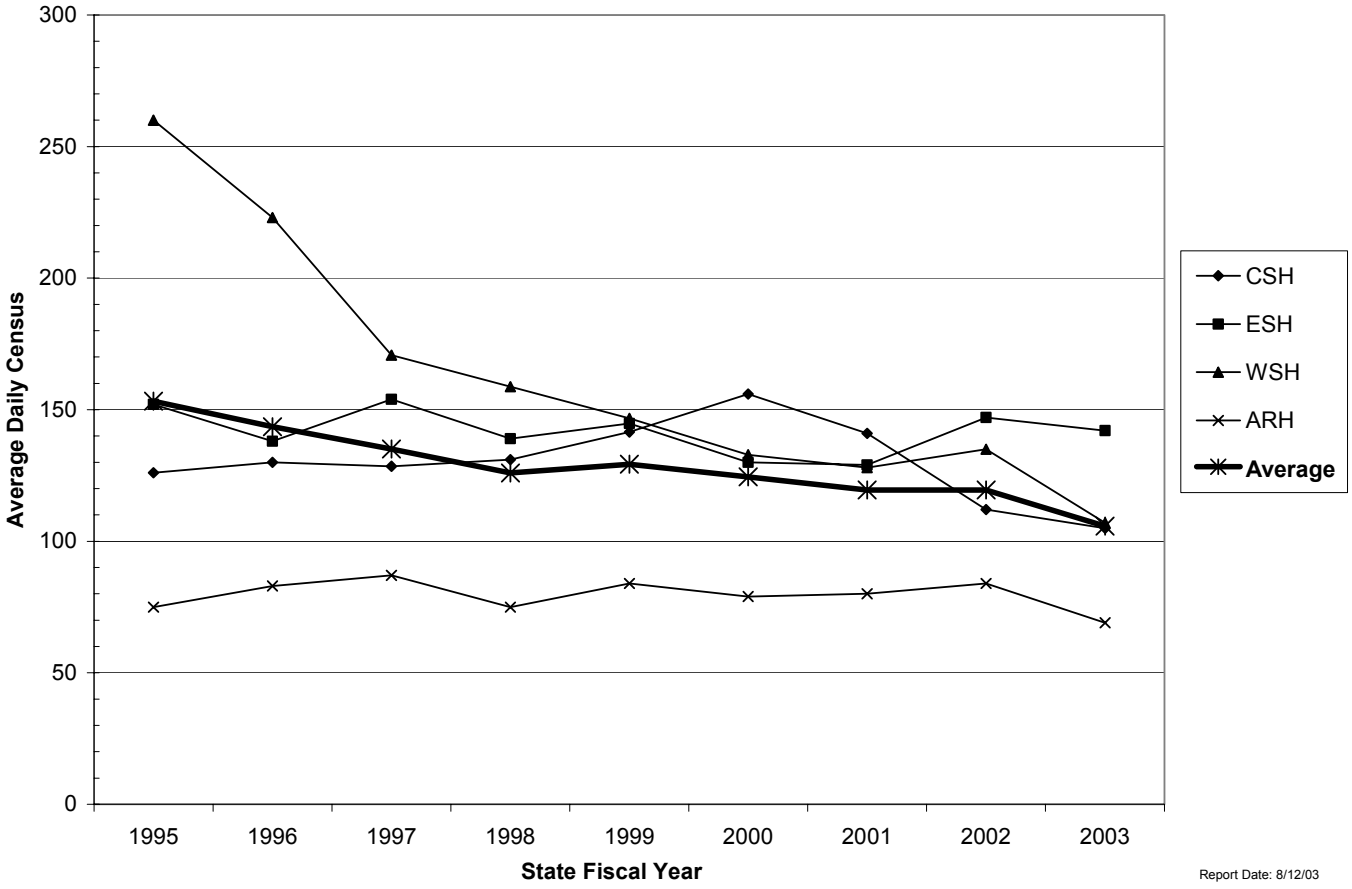
Strategies

The Division of Mental Health intends to partner with the Department for Public Health, the Research and Data Management Center at the University of Kentucky, the Regional MH/MR Boards and the Bristol Observatory to analyze the overlap between Regional MH/MR Boards and private psychiatric hospital utilization. Trends over time will be evaluated to determine if Departmental and Regional Board efforts have been effective.

Performance Indicators

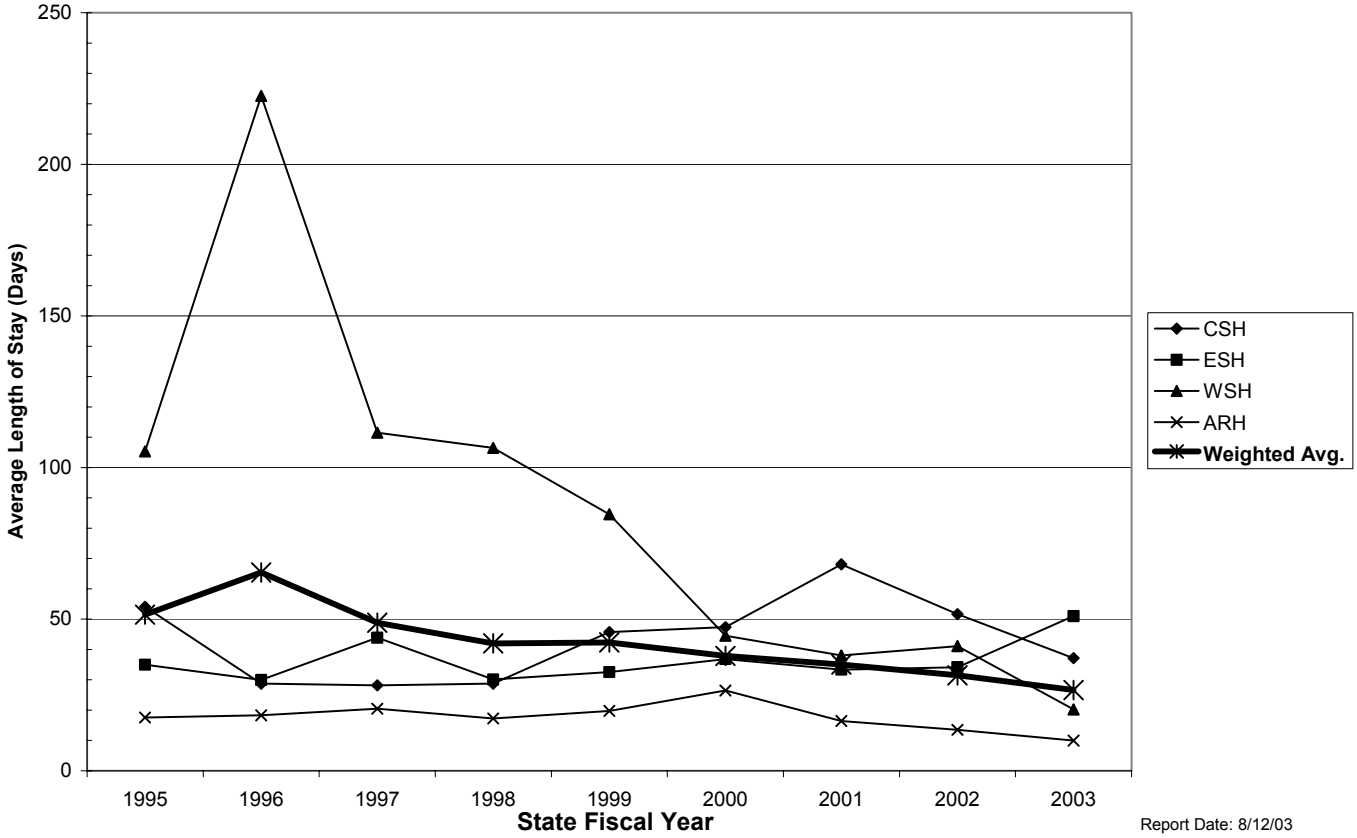
The following two charts display average daily census and average length of stay within state hospital settings. Performance indicators relating to readmission rate are addressed in the continuity of care section.

State Hospital Average Daily Census



Report Date: 8/12/03

State Hospital Average Length of Stay



Report Date: 8/12/03

Private Psychiatric Hospitals

Inpatient psychiatric services are available through community hospitals with licensed psychiatric beds to adults who are eligible for Medicaid and to indigent adults through disproportionate share dollars. Historically, KDMHMRS has not followed trends in the private psychiatric hospitalization of adults, because no KDMHMRS funds are involved and stays are relatively brief.

Continuity of Care

Introduction

The Department believes that addressing the issue of continuity of care through a well planned aftercare process is key to insuring a successful transition from the hospital to the community.

State Support

Providing appropriate aftercare following a state hospital stay is critical to reducing readmission rates. The Department requires a Regional MH/MR Board to provide an outpatient appointment within two weeks of a discharge. KDMHMRS also requires the provision of case management services to adults with severe mental illness who are discharged from a state psychiatric facility, are determined by hospital staff to be in need of
case management service, and agree to receive this service.

The fourteen Regional MH/MR Boards and the state operated/contracted psychiatric hospitals must work closely together to assure continuity of care. Contracts with all parties address continuity issues such as medications, discharge plans, case management and outpatient referrals. Some Regional MH/MR Boards function as single portal of entry for some of the hospitals. Due to the uniqueness of the providers and each individual they serve, a need to re-institute regular continuity of care meetings between the respective hospital and local Regional MH/MR Boards was identified in SFY 02 and KDMHMRS staff initiated the reconvening of these meetings. The agenda for each meeting included the following topics:

- Aftercare performance
- Community Medications Support Program
- Olmstead planning
- Continuity of care systems issues
- Consumer issues
- KDMHMRS Performance Indicators
- Other issues requested by participants

During SFY 04, KDMHMRS will be working with each of the state operated/contracted psychiatric hospitals and their assigned Regional MHMR Boards to develop a Memorandum of Agreement (MOA) between the two entities. In order to assure a seamless system of care, the need to develop these MOAs was

identified to strengthen the relationships between the hospitals and the Boards. The MOAs include the contractual responsibilities each entity has to the KDMHMRS, but also defines and clarifies roles and responsibilities the hospital and mental health center have to assure quality continuity of care to patients that they both serve.

Regional Roll-Up

KDMHMRS allocated new CMHS Block grant funds during SFY 2001 to develop two outreach specialist positions to evaluate the effectiveness of strategies to improve aftercare performance by Regional Boards. The Outreach Specialists focus on efforts to engage persons with severe mental illness who have either "served out" from a correctional facility or been recently discharged from a state psychiatric facility. Additional areas of focus for Regional MH/MR Boards include:

- Insuring outreach and seamless services to individuals in transition;
- Insuring that relevant services are available and accessible;
- Maintaining linkages with discharge planners, family members and others; and
- Monitoring relevant performance indicators (appointment follow-up, hospital readmission).

Trends/Challenges

While lengths of stay in state hospitals continue to decrease, continuity of care issues remain. A number of challenges are presented to KDMHMRS and the Regional Boards. These include:

- Private psychiatric beds have been closing or are being converted to acute care beds which generate more revenue;
- While crisis stabilization programs will exist in all fourteen regions by the end of SFY 04, confidence in their appropriateness as alternatives to hospitalization remains low among most psychiatrists; and
- Supervised residential options are sparse throughout Kentucky, thwarting efforts to discharge individuals with complex service needs.

Strategies

KDMHMRS uses a number of strategies designed to improve continuity of care including:

- Participating in continuity of care meetings convened by the four state hospitals;
- Producing a quarterly continuity of care report showing data trends; and
- Focusing on continuity of care issues in state hospital and Regional Board monitoring.

Performance Indicators

Two indicators have been selected to measure the performance of regional systems of care:

- *State Hospital Readmission*: a measure of the rate of re-admission of adults with SMI to a state hospital within 30 days of a previous discharge from the same facility.
- *Continuity of Care – Outpatient Care*: a measure of the percent of discharges (adults with SMI) who are seen for an outpatient appointment within 7,14 and 30 days after discharge from a state hospital.

See Appendix A: Performance Indicators

Objectives

Regional MH/MR Boards submitted the following plans in the area of continuity of care:

Region	Plan
1	Continue to provide staff to attend the Continuity of Care meetings held at Western State Hospital and make weekly visits to facilitate continuity of care for hospitalized individuals from our region.
2	Work with WSH to improve the time lag in obtaining "Discharge Summaries" as well as improving the quality of the "interdisciplinary termination note". This will occur in the first biennium. Key components of discharge summaries will be available to Center staff at the time of discharge.
3	Representative will meet with WSH on a bi-weekly basis.
4	Maintain 14-day aftercare appointment rate of 93%.
5	Will maintain hospital readmission rate within one standard deviation of statewide average.
6	Will continue to demonstrate lower than average for hospital readmission rates.
7	By the end of September 2003, the Director of Adult Services, ACCESS staff and the CSP Coordinator will meet to develop a plan for follow-up on SMI clients referred by ESH who do not show for initial appointments after discharge.
8	CSP staff shall participate in at least 80% of all continuity of care meetings with Eastern State Hospital.
9/10	Continue to refine our system to identify.
11	CSP staff will continue to participate in 90% of all continuity of care meetings with Hazard ARH.
12	During FY 2004, should additional resources become available, KRCC will strive to reduce the readmission rates to the state psychiatric hospital through the employment of additional case management and community support program staff.
13	Facilitate improved communication with ARH representatives to increase continuity of care, referrals to case management, and community relationships by June 30, 2004.
14	Continue to work with Eastern State Hospital in developing memorandum of agreement, as well as attend continuity of care meetings. Maintain current level of care.
15	With PCP's. Maintain at or below current rate of re-admission to inpatient services.

- **Objective A-1-10: Convene quarterly continuity of care meetings in each of the four hospital districts during SFY 04 to include representatives of the hospital, corresponding specialized personal care homes, and the corresponding Regional MH/MR Boards. Assure the development of Memorandums of Agreement between state operated/state contracted hospitals and Regional MH/MR Boards.**

Case Management Services

Introduction

Case management is an essential Community Support Service because it coordinates an individual's service array, making maximum use of available formal and informal supports. Case management has been available through Regional MH/MR Boards since 1985 and was first covered by Kentucky Medicaid in 1991. Priority is given to adults with severe mental illness who have the greatest difficulties accessing services and those with more intense service needs. Kentucky embraces a strengths based model advocated by the University of Kansas (Dr. Charles Rapp).

State Support

KDMHMRS supports Regional MH/MR Boards in a variety of ways:

- The Division of Mental Health, Adult Services Branch, designates a statewide coordinator of case management services;
- KDMHMRS requires and provides certification training for all case managers within six months of employment;
- KDMHMRS, in collaboration with the statewide Case Management/Service Coordination Advisory Committee, conducts a continuing education conference that is specific to developing best practices in case management ;
- KDMHMRS funds demonstration projects for the provision of case management services of a more intensive design to persons with severe mental illness who have a history of violent or volatile behavior; and
- Evidence-based practices such as Assertive Community Treatment are being studied for possible implementation in the regions.

Regional Roll-Up

A review of the information from the SFY 04 regional plan applications submitted as part of the Regional MH/MR Boards' Annual Plan and Budget submission reveals that case management services are available in all 120 of Kentucky's counties. Currently, over 6900 individuals are served by 200 case managers. Additionally, case management in Kentucky provides support to individuals in a variety of ways including:

- Two regions have an Assertive Community Treatment Team;
- One region has a mobile outreach team;
- Two regions provide specialized intensive case management for forensic clients and;
- Four regions provide continuity of care case management for special populations.

Trends/Challenges

The delivery of quality, timely case management services is challenged by a number of factors including:

- The current billing system considers four contacts per month a unit of service. Contacts above or below this figure are not reimbursed;
- During SFY 03, Kentucky Medicaid rates for case management were capped (due to deficits in the overall state Medicaid program); and
- Turnover among case managers is high; in general case managers have less status than outpatient clinicians and this "service" is often viewed as an entry level position.

Strategies

The Division's case management coordinator uses a number of strategies to advance quality case management services at the regional level. Strategies include:

- Provision of initial and ongoing technical assistance and consultation to case managers and their supervisors;
- Sponsorship of advanced training opportunities such as the annual Case Management Level II training; and
- Promotion of evidence-based or "best" practices (such as Assertive Community Treatment).

Family and community advocates are asking the Department to develop programs that enable Regional MH/MR Boards to reach out to adults with severe mental illness with specialized case management and mobile treatment teams. Many communities elsewhere in the nation have implemented "Assertive Community Treatment" (ACT) programs in response to similar initiatives. KDMHMRS has coordinated specific efforts to assist in this consensus building process through the following initiatives:

- The Department convened a statewide conference hosting national trend-setters in May 2001 to stimulate discussion of ways to reach out to individuals in communities who are difficult to treat;
- ACT models have been introduced and discussed at quarterly Community Support Program (CSP) meetings, the annual Mental Health Institute, and the annual Case Management Conference; and
- Efforts to address consumer concerns about ACT model development and implementation were initiated by facilitating a focus group about ACT during a KYCAN Board meeting.

Performance Indicators

Two indicators have been selected to measure the performance of regional systems of care. These include:

- *Case Management Penetration Rate*: a measure of access to targeted case management by adults with severe mental illness.
- *Continuity of Care – Case Management*: a measure of access to targeted case management by adults with severe mental illness upon discharge from state psychiatric facilities.

See Appendix A: Performance Indicators

Objectives

It is anticipated that in SFY 04, increases in case management penetration rates at the regional level will be limited by the freezing of Kentucky Medicaid rates as well as the need to serve individuals with more severe needs (e.g. individuals who meet

the Olmstead profile). Regional MH/MR Boards submitted the following plans in this area:

Region	Plan
1	Increase average SMI Service Coordinator caseloads to the level required to meet their productivity standard.
2	Cross-train 50% of SMI case managers in the area of substance abuse (dual diagnosis) to better service this population.
3	Train all case managers in supported employment procedures.
4	Access to targeted case management will be increased by 1% over FY 2003 rates.
5	All Performance Indicators will remain within one standard deviation from statewide average.
6	All Case Managers will be trained in the use of the MCAS and all consumers who receive CM will have MCAS completed.
7	By September 2003 the Case Management Coordinator and the case managers will identify two action steps to help increase access to targeted case management. By January '04 at least one of these action steps will be implemented.
8	Ensure that at least 95% of referrals to case management services are assessed within three working days.
9/10	Continue to use a case manager as liaison to Eastern State Hospital.
11	MCCC will continue to provide in excess of 50% of all face-to-face CM services in each consumer's natural environment.
12	Pursue rule changes with DMH/MRS and the Division of Medicaid to permit Case Managers to be hired based upon competence rather than the current requirements for education and prior experience working with severely mentally ill persons.
13	Facilitate improved communication between ARH and CRCCC by June 30, 2004. This objective has been difficult to accomplish due to staffing changes at ARH, lack of referrals for case management, loss of liaison, and infrequent continuity of care meetings.
14	Maintain current number of staff (17 case managers).
15	Maintain the current penetration rate for access to targeted case management.

During SFY 04, efforts will continue to involve stakeholders in identifying key components essential to an ACT model particular to Kentucky, as well as to explore potential funding mechanisms. Additionally, DMH staff will continue to provide technical assistance to existing, modified ACT programs operating in the state.

- **Objective A-1-11: Contingent on funding, plan, implement and evaluate two pilot ACT programs in the state (one program will serve a rural area; the other an urban area). Enlist stakeholder participation in program development and review. Prepare biennium funding request during SFY 04.**

Rehabilitation Services

Introduction

KDMHMRS incorporates the philosophy of "psycho-social rehabilitation" (outcomes improve when skills are taught in a social setting) and **"**recovery**"** (outcomes and satisfaction improve when consumers help manage symptoms of their illnesses) to assist the development of Community Support Services. As psychiatric rehabilitation technology has evolved, KDMHMRS has promoted rehabilitation and recovery

models through training, education, technical assistance, and targeted funding opportunities.

State Support

KDMHMRS promotes the use of psychiatric rehabilitation technology by regional programs. The Psychiatric Rehabilitation model developed by the Center for Psychiatric Rehabilitation at Boston University was selected as the exemplary model as it has been extensively documented, validated, and replicated in hundreds of different settings for over two decades. This model also addresses the four major components of Community Support Services identified by KDMHMRS with a focus on improving the lives of persons with psychiatric disabilities by enhancing their use of skills and/or environmental supports to live, learn, work, and socialize in the community and role of their choice.

Currently KDMHMRS, Kentucky Medicaid, the Regional MH/MR Boards, and other providers have not adopted a specific model of practice with stated values, principles, practice guidelines, and expected outcomes of service. Some programs have independently adopted various models but, without system support, have had difficulty implementing and maintaining a commitment to training and outcome measurement. The Psychiatric Rehabilitation model offers a method that would specifically address improvement in skills, functioning, social environment, and role attainment with a proven process, intervention, and technology base.

KDMHMRS supports the provision of three key rehabilitative services at the regional level: therapeutic rehabilitation, supported employment, and supported education. While they each rely on psychiatric rehabilitation technology, they are supported in very different ways.

Therapeutic rehabilitation programs are goal directed services aimed at improving skills in living, working and socializing in communities of one's choice. Technical assistance is provided to regional programs in how to incorporate psychiatric rehabilitation technology into daily programming.

KDMHMRS has an interagency agreement with the Department for Vocational Rehabilitation that uses CMHS Block Grant funds to leverage **supported employment** services for adults with severe mental illness. New block grant funds were used to increase the allocation under the interagency agreement in SFY 02. In addition, KDMHMRS worked collaboratively in SFY 02 with the Kentucky Business Leadership Network to increase employment opportunities for adults with severe mental illness through community awareness and education and the implementation of a job placement website for adults with disabilities.

Efforts during SFY 03 focused on bringing stakeholders together to implement provisions of the Ticket to Work and Work Incentives Improvement Act of 1999, legislation that has major implications for individuals with psychiatric disabilities, as well as all persons with disabilities. In addition, a concentrated focus was placed on the need for advocacy and for potential new supported employment funding for long-term supports.

Efforts during SFY 04 will focus on working with the HB 843 Supported Employment Workgroup to advocate and plan for additional long-term supports, new employment funding, and expansion of supported employment options.

Improving access to **educational services** through sites that provide Community Support Services is a new priority for SFY 04. According to the Kentucky Adult Literacy Survey, which is designed to provide information concerning literary proficiencies in the state, over 340,000 people lack the literacy skills necessary to compete in the workforce. Lack of literacy skills act as a hindrance to the personal advancement of another 656,000 Kentuckians. The lack of available educational services can seriously hinder persons with a serious mental illness in accessing and maintaining employment, and can negatively impact their quality of life.

Regional Roll-Up

A review of the information from the SFY 04 regional plan applications reveals that while therapeutic rehabilitation programs are available in most Kentucky counties, supported employment and supported education services remain underdeveloped at best. Access to rehabilitative services can be described in a variety of ways including:

- All fourteen regions offer Therapeutic Rehabilitation (TR) services;
- Ten regions offer Supported Employment services;
- Three regions offer Education services;
- Ten regions provide specialized training to TR program staff; and
- Nine regions state that they are involved in a “best” or “evidence-based” practice in the area of rehabilitation.

Trends/Challenges

While KDMHMRS staff have spent a considerable amount of time over a number of years in promoting evidence-based and “best” practices, true rehabilitative services that support individual preferences for work, living and socialization remain underdeveloped. Further, individual outcomes (e.g. employment) remain at very low levels. Other challenges for the system include:

- Beyond the Therapeutic Rehabilitation service, no billing mechanism exists for supported employment or supported education;
- Training in psychiatric rehabilitation practice is time consuming, expensive and requires a change in attitudes of some administrative staff; and
- There is little understanding of rehabilitation technology at the regional level.

Strategies

Training opportunities are a primary strategy used to create change. The annual Mental Health Institute routinely sponsors national presenters in the areas of psychiatric rehabilitation and supported employment. Staff follow-up with technical

assistance and consultation to local programs motivated to incorporate new learning into programming.

KDMHMRS has submitted a number of federal grant applications designed to reach consensus about adopting psychiatric rehabilitation technology among regional programs. To date, none of these Community Action Grants have been funded. Staff continue to pursue federal evidence-based practice grants (e.g. planning, education and training) in hopes that new, targeted funding can galvanize local programs into action.

An additional strategy that has been very successful is the sponsorship of regional staff in securing their International Association of Psychosocial Rehabilitation Services (IAPSRS) credentials. This spring, over 30 regional staff availed themselves of this opportunity and sat for the IAPSRS test in Louisville. It has been a goal of the DMH to increase the number of certified rehabilitation staff at the local level.

Performance Indicators

Two indicators have been selected to measure the performance of regional systems of care. These include:

- *Employment Rate*: a measure of employment by adults with severe mental illness served by Regional MH/MR Boards.
- *MCAS Penetration Rate*: a measure of the percentage of adults with severe mental illness receiving therapeutic rehabilitation services who have been assessed for level of functioning.

See Appendix A: Performance Indicators

Objectives

Regional MH/MR Boards submitted the following plans in this area:

Region	Plan
1	Continue to evolve the role of the two TR programs from county-specific service delivery to area (multi-county) service delivery.
2	Expand the potential to manage Olmstead clients through the creation of an additional case management position to be charged through the Olmstead fund source (one FTE).
3	Complete Multnomah Community Ability Scale evaluations on all TRP clients.
4	85% of consumers entering TR will receive baseline MCAS scores.
5	Each SMI Case Manager will contact Vocational Rehabilitation monthly in their respective counties.
6	Correct data collection system for employment rate will be put in place.
7	The Director of Adult Services along with the Vice President of Outpatient Services and the adult services staff who work in Carroll County will explore the feasibility of restarting a TRP in Carrollton.
8	Ongoing assessment of TR programming based upon information revealed through clinical assessment of functioning.
9/10	Implement use of the Multnomah Community Ability Scale in all components of CSP.
11	Two additional CMs have been trained during this report period. Goal: Train 100% of Case Managers in the Boston University Case Management Technology.
12	Develop a plan for the utilization of the Caney Creek Rehabilitation Complex "Caney on 15" site as an adjunct site for community support services which permits severely mentally ill clients to learn and practice vocational skills.
13	Each TRP will identify at least one person who could qualify from supported employment by June 30, 2004.
14	Maintain current number of staff (28 therapeutic rehabilitation staff). Maintain current level of care.
15	Continue to perform at or above state average for employment rate of SMI consumers.

- **Objective A-1-12: Implement the Multnomah Community Ability Scale functional assessment tool within the Targeted Case Management program in SFY 04.**

- **Objective A-1-13: Convene quarterly CSP meetings to adopt and implement principles of Psychiatric Rehabilitation, Supported Employment, Supported Education and Supported Housing in Kentucky. Develop a curriculum for Therapeutic Rehabilitation Programs that includes Psychiatric Rehabilitation, Supported Employment and Supported Education principles.**

- **Objective A-1-14: In collaboration with the Department of Vocational Rehabilitation, continue efforts with stakeholders in Supported Employment programs to identify and implement expansion opportunities, as well as implement provisions of the Ticket to Work and Work Incentives Improvement Act, and participate in exploring the feasibility of developing a Kentucky Medicaid buy-in proposal.**

Housing Options

Introduction

The Department embraces a "Supported Housing" approach to providing housing options for adults with severe mental illnesses. Supported Housing involves the linking of affordable, permanent, community-based housing options with flexible services and supports. It also assumes that individuals have preferences and should be involved in choosing where and with whom they live.

State Support

CMHS Block Grant funds have been critically important to the development of the KDMHMRS housing initiative, which focuses on affordable housing development while promoting linkages with housing related supports such as skills training, assistance in securing subsidies, and housing search activities.

KDMHMRS began funding a full-time **Statewide Housing Coordinator** in 1993 to work with consumers, Regional MH/MR Boards, and the Kentucky Housing Corporation (KHC) to develop housing options. The Housing Coordinator supports local efforts through:

- On-site technical assistance with local housing developers;
- Quarterly housing meetings;
- Special training events; and
- Collaboration with the Kentucky Housing Corporation, the Housing and Homeless Coalition in Kentucky, the State Housing Policy Advisory Committee, the Council on Homeless Policy and other key state housing organizations.

Additionally, KDMHMRS collaborates with KHC in two key initiatives:

- The **Supportive Housing Specialist** position, which is jointly funded by the KHC and KDMHMRS, works to further integrate the housing needs of persons with mental illness into the state housing finance agency's programs. Technical assistance and consultation in developing housing projects is provided to local nonprofits by the Specialist.
- KDMHMRS provides $400,000 in annual funding to KHC to create a "set-aside" account within KHC's **Affordable Housing Trust Fund (AHTF).** The AHTF (established in 1996) uses unclaimed lottery proceeds to spur development of new housing projects for individuals with mental health, mental retardation or developmental disabilities, or substance abuse problems. Through December 2002, approximately 41 projects housing the Department's priority populations have been developed. These projects have provided 390 units in a mix of permanent and transitional housing settings.

Regional Rollup

During SFY 04, the Department, KHC and the Kentucky Association of Regional Programs will continue collaborating on the development of a **Statewide Housing Project** involving low-income housing tax credits. This project involves the construction of twelve new units of scattered site affordable rental housing in a number of rural counties. Regional MH/MR Boards will serve as local project sponsors and be responsible for site selection, construction, tenant selection, property management and service provision.

Regional MH/MR Boards use a variety of strategies to develop housing options for individuals with severe mental illnesses. Some focus on actual housing development by employing regional housing developers; others focus on housing access by administering their own Section 8 set-aside programs or through collaborative arrangements with local public housing agencies. A review of the information from the SFY 04 regional plan applications reveals that:

- Eleven Regional Boards are actively involved in housing development;
- Ten regions operate housing projects that provide residential support;
- Seven regions have organized formal supported housing programs;
- Seven regions report having developed a regional housing plan; and
- Eleven regions provide specialized housing training to agency staff.

Trends/Challenges

While most Regional Boards recognize the need to develop housing options for their clients, affordable housing development can never be the central mission of the organization. More partnerships are needed with local public housing agencies, nonprofit and for profit housing developers, and other housing and service agencies. The need is too great for one agency to secure all the resources needed. Other challenges facing Regional Boards include:

- There is no dedicated source of funding for housing related support services;
- Existing residential and housing programs have not received an increase in funding for at least ten years;
- There are a lack of nonprofit housing developers in a number of rural counties;
- Disability advocates have yet to craft a common agenda around affordable housing issues; and
- A lack of knowledge and expertise about the low-income housing development and management process exists.

Strategies

A number of strategies are used by the Division's Housing Coordinator. These include:

- Establishing an email newsletter to disseminate housing information to statewide contacts;

- Promoting rental assistance program development;
- Educating staff about accessing the subsidized housing delivery system;
- Participating in Olmstead planning activities and Kentucky's Real Choices grant implementation; and
- Providing technical assistance to local nonprofit housing developers through referral to KHC's Supportive Housing Specialist.

Performance Indicators

One indicator has been selected to measure the performance of regional systems of care:

- *Living Independently*: a measure of residential status by adults with severe mental illness.

Staff and consumers continue to discuss the need for a more consumer centered or person centered outcome measure, such as the percentage of individuals who are living in preferred settings.

See Appendix A: Performance Indicators.

Objectives

It is anticipated that in SFY 04, Regional MH/MR Boards will continue to develop a modest amount of new housing units. A lack of targeted service funding will, however, remain a major deterrent to increasing the rate of development. Regional MH/MR Boards submitted the following plans in this area:

Region	Plan
1	Facilitate a housing option for the SMI population through the Fuller Apartments, once the facility is open.
2	Through a special housing option offered through the State (CMHC) Association, KARP, the Pennyroyal Center will construct and open at least four residential units for persons with SMI within Fiscal Year 2004. The Pennyroyal Center will continue to work with the local housing authorities in each area served by the Center in order to increase the Section 8 housing vouchers available by six within Fiscal Year 2004. This will require the cooperation of the local housing authority and will hinge on its ability to have its plan approved by the Kentucky Housing Corporation.
3	Complete four housing placements each month.
4	Increase families housed by four.
5	Maintain performance indicator within one standard deviation (living independently).
6	Correct data collection system for independent living status will be put in place.
7	Funds that were previously utilized in the Transition Apartment Program will be used to expand housing support services. The type and intensity of services to clients in the housing support programs will be determined by consumer needs and preferences thus establishing housing as a basic right.
8	Collaborate with the Housing Authority of Maysville and the Women's Crisis Center to apply for HUD housing funds. Provide case management services to all persons served through the grant if the application is successful.
9/10	Asking for funding for two staff to work exclusively with SMI who move.
11	Increase housing development funds by 25% in FY 04.
12	During FY 2004 KRCC will submit at least one application for affordable housing for the seriously mentally ill to the Kentucky Housing Corporation and complete current projects.
13	Facilitate applications for new apartment complexes in Corbin and Harlan. Applicants who reside in the Residential Programs will be screened for appropriateness and needed support by June 30, 2004.
14	Maintain number of units/beds (when transitional duplexes completed). Apply for Continuum of Care dollars for Supportive Housing and Emergency Shelter Grants as well as PATH Grant.
15	Maintain the current rate of individuals with SMI who are living independently. Conduct consumer survey focused on issues of safety and availability of housing.

- **Objective A-1-15: Prepare biennium budget request during SFY 04 for targeted housing supports funding that would be linked with Kentucky Housing Corporation's "Open Window" housing funding process.**

- **Objective A-1-16: Convene statewide housing meetings at least three times per year that provide relevant training for consumers, family members, case managers, clinicians, and other stakeholders.**

- **Objective A-1-17: Develop an email directory or Listserv for use in disseminating housing information.**

Other Mental Health Initiatives

KDMHMRS staff are involved in a number of other initiatives which strengthen community mental health services to adults with severe mental illness. These initiatives include:

Specialized Co-Occurring Disorders Initiatives

HB 843, which established the Kentucky Commission on Services and Supports for Persons with Mental Illness, Alcohol and other Drug Abuse Disorders and Dual Diagnosis, issued their final report in June 2001. Included in this report were two significant recommendations related to co-occurring disorders. The Commission emphasized a need for increased initiatives related to cross-systems training for both mental health and substance abuse professionals, as well as the development of more integrated service delivery systems, both at the state and local levels.

During SFY 04, KDMHMRS hopes to implement a SAMHSA-sponsored co-occurring state incentive grant award of up to 1.1 million dollars. This grant is intended to "develop and enhance the infrastructure of states and their treatment service systems to increase the capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring substance abuse and mental health disorders and their families."

KDMHMRS promotes additional initiatives including:

- Mandatory training for all adult service case managers and their supervisors includes a two-hour training session on co-occurring disorders.
- The Kentucky School for Alcohol and Drug Studies and the Mental Health Institute provide training on co-occurring disorders for consumers, family members and providers.

❖ **Objective A-1-18: Promote the development of additional integrated service programs for individuals with co-occurring disorders, along with the provision of cross-training events.**

Older Persons

The elderly population is one of the fastest growing populations in the United States. Older persons with a severe mental illness are often under-served and their needs are not met. In Kentucky, the elderly (over 60) population represents fourteen percent of adults with a severe mental illness who are served by Regional MH/MR Boards. In order to promote public awareness and to improve services to the elderly, KDMHMRS collaborates with multiple agencies that serve older persons. Staff serve on planning boards, commissions and task forces in order to promote

inter-agency collaboration. The KDMHMRS also provides financial support and staff to the state level Kentucky Mental Health and Aging Coalition, which was established in October of 1999. The coalition meets at least quarterly and consists of consumers, providers, academic, legislative and other advocacy groups. Funding and support is also provided to coalitions at the regional level.

Through the Mental Health Institute, PASRR trainings and the Case Management Conference, KDMHMRS ensures training opportunities are provided for staff of Regional MH/MR Boards on the mental health needs of older adults. Scholarships are offered to facilitate attendance at the Annual Summer Series on Aging Conference by mental health professionals who work with the elderly and are involved in the PASRR Program. Local mental health and aging coalitions provide training through conferences and workshops in their regions to consumers, caretakers, providers, and others with funds provided by the KDMHMRS. Staff work in partnership with the Ohio Valley Appalachia Regional Geriatric Education Center (OVAR/GEC) which provides specialized training on the mental health needs of older adults for mental health professionals involved in the PASRR program.

The Kentucky Mental Health Services Planning Council added a representative from the state Office of Aging during SFY 00 in order to place greater emphasis on the mental health needs of the elderly.

The House Bill 843 Aging Workgroup continues to meet on a quarterly basis and has presented a report of their findings to the Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders and Dual Diagnosis. The Workgroup has established a charge and is working toward making recommendations to eliminate gaps and barriers in services to the elderly.

Objectives

Regional MH/MR Boards submitted the following plans in the area of specialized services to the aging:

Region	Plan
1	Continue to provide staff to conduct consultations to the jails on non-consumer specific behavioral health issues.
2	The Pennyroyal Center will contact the three regional jails to outline service expectations and specified roles of each organization during FY 2004.
3	Train all jails on suicide prevention.
4	Provide one inservice training for each county jail in the region.
5	Will enter into formal contract agreements with all Regional Jails in FY04.
6	Implement training of jail personnel in identifying and managing mentally ill inmates at Shelby, Bullitt, and Oldham Counties.
7	NorthKey staff will provide two mental health trainings to Regional jail staff in the next year (two will be done in FHY '03 and two will be done in FY '04). A plan for ongoing training will be developed (e.g. develop training video and/or schedule additional trainings both refresher courses and more advanced versus basic training).
8	Increase the number of contractual agreements with local jails in our region by at least one in FY 2004.

9/10	Complete the training with the five local jails and meet with new law enforcement.
11	Continue to develop plan for tracking outreach rate/criminal justice by July 1, 2004.
12	During the upcoming biennium, KRCC will endeavor to contract with at least one jail for jail-based services, pending the jail's development / availability of resources for this contract. Jail based training services will be offered to all jails in the region.
13	Continue collaboration with local jails and continue existing memorandums of agreement on the provision of mental health/substance abuse services. This objective will be accomplished by contacting each jail six months through June 30, 2004.
14	Organization is above statewide penetration rate. Maintain current level of care.
15	Increase the number of contractual agreements with local jails in our region.

- **Objective A-1-19: Continue to promote public awareness of the mental health needs of older adults through participation on planning boards, task forces and coalition activities.**

- **Objective A-1-20: In collaboration with primary care practitioners, explore the development of a program to extend mental health services to the aging.**

Criminal Justice Interface

Since the implementation of a multi-faceted legislative initiative in 1994, Kentucky has eliminated the use of jails during acute psychiatric crises and the involuntary hospitalization process. Instead, consumers are evaluated in emergency rooms or by staff of Regional MH/MR Boards. These efforts have:

- Increased understanding of mental illness by emergency responders such as ambulance drivers, paramedics, and peace officers;
- Improved access to evaluation and treatment;
- Improved communication among local peace officers, judges, mental health professionals, other community resources and the general public; and
- Reduced the stigma and trauma of involuntary hospitalization.

KDMHMRS has intensified efforts to build an integrated service system for individuals with serious and persistent mental illness who are involved in the criminal justice system. The need for collaboration among Kentucky's Divisions of Mental Health and Substance Abuse, the Kentucky Department of Corrections, and other stakeholders in our communities' "safety net" to serve persons with mental illness has become an increasingly apparent need.

One of the HB 843 workgroups focuses on individuals with severe and persistent mental illness involved with the criminal justice system and the interface between both systems. The Criminal Justice/Behavioral Health (CJ/BH) Workgroup, which is chaired by the Executive Director of the Kentucky Criminal Justice Council and staffed by KDMHMRS, has a very clear charge for SFY 03 that was mandated during the 2002 legislative session. This workgroup has focused specifically on the development of a curriculum for county jailers and their staff. The curriculum covers the identification of persons with mental illness and substance abuse problems, crisis de-escalation and suicide prevention. During SFY 03, KDMHMRS conducted

a training of the trainers for each of the Regional MHMR Boards in the state. Participants then returned to their communities and provided this training to the staff of local jails. This training will be provided in SFY 04 at a minimum of every six months. The CJ/BH Workgroup also made recommendations specific to the content of “model working agreements” at the local level among mental health centers and local jails. Lastly, this workgroup will be reviewing the civil commitment statute in Kentucky, KRS 202A, for possible language changes to be addressed during for the 2004 legislative session.

KDMHMRS will continue to utilize block grant funds to partner with NAMI Kentucky to fund a cross-systems training coordinator during SFY 2003 (See Criterion Five). This position will continue to work across multiple systems (including mental health, mental retardation, substance abuse, corrections, criminal justice training, jailers association, and Kentucky State Police) to advocate for and coordinate training modules for police officers that encounter persons with behavioral health disabilities.

Objectives

Regional MH/MR Boards submitted the following plans in the area of criminal justice interface:

Region	Plan
1	Continue to provide staff to conduct consultations to the jails on non-consumer specific behavioral health issues.
2	The Pennyroyal Center will contact the three regional jails to outline service expectations and specified roles of each organization during FY 2004.
3	Train all jails on suicide prevention.
4	Provide one inservice training for each county jail in the region.
5	Will enter into formal contract agreements with all Regional Jails in FY04.
6	Implement training of jail personnel in identifying and managing mentally ill inmates at Shelby, Bullitt, and Oldham Counties.
7	NorthKey staff will provide two mental health trainings to Regional jail staff in the next year (two will be done in FHY '03 and two will be done in FY '04). A plan for ongoing training will be developed (e.g. develop training video and/or schedule additional trainings both refresher courses and more advanced versus basic training).
8	Increase the number of contractual agreements with local jails in our region by at least one in FY 2004.
9/10	Complete the training with the five local jails and meet with new law enforcement.
11	Continue to develop plan for tracking outreach rate/criminal justice by July 1, 2004.
12	During the upcoming biennium, KRCC will endeavor to contract with at least one jail for jail-based services, pending the jail's development / availability of resources for this contract. Jail based training services will be offered to all jails in the region.
13	Continue collaboration with local jails and continue existing memorandums of agreement on the provision of mental health/substance abuse services. This objective will be accomplished by contacting each jail six months through June 30, 2004.
14	Organization is above statewide penetration rate. Maintain current level of care.
15	Increase the number of contractual agreements with local jails in our region.

- **Objective A-1-21: Provide technical assistance during SFY 04 to Regional MH/MR Boards in implementing required jailer training.**

- **Objective A-1-22: Design and implement a sustained training program for Regional MH/MR Board staff and their criminal justice collaborators on 202A / crisis triage, targeting issues related to co-occurring disorders.**

<u>Traumatic Brain Injury</u>

The Brain Injury Services Unit was established as an office of the Division of Mental Health in January 1999 to administer the Acquired Brain Injury Waiver Program initiated by the 1998 Kentucky General Assembly. Brain Injury Services Unit staff provide assistance to the Traumatic Brain Trust Fund Board, a statutory board, in its efforts to meet the needs of individuals with brain injury.

In 2000, the Brain Injury Services Unit (BISU) completed a comprehensive statewide assessment of the service needs of people with brain injuries in Kentucky, and the resources available to meet those needs. These activities were funded by a grant

from the U.S. Department of Health and Human Services, Bureau of Maternal and Child Health, and the Traumatic Brain Injury Trust Fund. A survey of Regional MH/MR adult program sites revealed that almost half of the sites' consumers have suffered a brain injury.

Also during 2000, the BISU submitted a waiver amendment to the Healthcare Financing Administration (HCFA) in order to allow the delivery of residential and supported employment services to individuals served under the existing waiver program. This waiver amendment was approved in July 2001. In SFY 2002, the brain injury program enrolled three residential providers and five supported employment providers.

- **Objective A-1-23: Continue development of residential and supported employment services for persons with brain injury during SFY 04.**

Physical Health

Introduction

The interface of physical health and mental health is of growing importance to providers of behavioral health services. It is well known that a significant amount of behavioral health services are provided in the physical healthcare arena. Continuity of care across these systems is critical if individuals are going to recover and succeed in establishing chosen roles in the community.

State Support

To help focus on improving access to dental and physical health services, a representative of the Department for Public Health was recommended as a member of the Kentucky Mental Health Services Planning Council. That representative has been attending planning council meetings during SFY 03 and contributing valuable suggestions for collaboration between the physical health and mental health system.

Regional Roll-Up

Regional MH/MR Boards are required to assess the physical health of each consumer they serve. Clinicians and case managers work closely with parents, community primary care physicians, local Health Departments, other health care providers, and schools to address the overall health needs of adults. Physical health services are available through Medicaid or local "free" clinics that provide indigent health care.

Regional Boards report the following activities in their plans for SFY 04:

- All fourteen regions state that physical health needs are addressed when individual service plans are developed;
- Eleven regions track clients who receive a physical or dental exam directly or by CMHC referral and follow-up;

- Eleven regions have formal or informal initiatives with physical health providers; and
- Seven regions report having a process for tracking referrals to Public Health Departments or primary care providers.

Trends/Challenges

While Medicaid provides a significant benefit for physical health care for many individuals with severe mental illness, many still do not have access to care. Individuals still visit hospital emergency rooms for routine physical health care. Other challenges include:

- Inability to afford costly physical health medications;
- Lack of follow-up by consumers with prescribed health regimens for chronic conditions (e.g. diabetes, heart disease);
- Limited formal agreements between primary care settings and Regional Boards; and
- Few examples of physical health and mental health service integration.

Strategies

KDMHMRS encourages the use of formal or informal agreements between Regional Boards and local primary health care providers. It also monitors for the quality of care provided in assessing and arranging for the treatment of physical health conditions among individuals with mental illnesses. Ultimately, the development of performance indicators is necessary to insure that a consistent level of attention to physical health care needs is provided.

Performance Indicators

No performance indicators have yet been selected for this area. Potential indicators include:

- Percentage of individuals that have physical health screen completed.
- Percentage of individuals with severe mental illness who have annual physical examinations.
- Number of formal memorandum of agreements between Regional Boards and public health or other primary care agencies.
- Mortality rate.

Objectives

Regional MH/MR Boards submitted the following plans in the area of physical health interface:

Region	Plan
1	Continue to provide this interface through the Service Coordination component of the interventions with the SMI population.

2	Under the crisis stabilization service, the Pennyroyal Center will establish contractual agreements with private and public healthcare providers in Caldwell, Christian, Hopkins and Muhlenberg counties to obtain histories and Physicals that permit the placements of clients in crisis to PCH beds.
3	Complete pain management assessments on all new TRP clients.
4	All incoming consumers will be referred for physical exams.
5	Will institute system to track referrals to Public Health.
6	Collaborate with Spencer County in applying for a HRSA grant through Park Duvalle.
7	NorthKey will maintain the current level of services at Dixie Pike Healthpoint location. The Crisis Stabilization Services Coordinator will prepare a mailing to send out to local primary care physicians to provide basic information about eh new crisis stabilization services.
8	Continue to provide current interface with local health care providers, including use of wraparound funds for physical health care needs.
9/10	Utilize physician's examination form as a tool to discuss mental health issues with their general practitioners.
11	Continue to track request for annual physical exams for SMI consumers through UR review.
12	KRCC mental health staff will provide client services in at least two physical health provider sites during FY 2004 and focus on opportunities for integrated health and mental health services.
13	Continue outreach and collaboration with local primary physicians and health departments on mental health services and availability. This will be accomplished by providing pamphlets to the physicians and health departments every six months.
14	Maintain current level of care.
15	Data from record reviews will show increased trend to communicate.

- **Objective A-1-24: Evaluate performance indicators for measuring regional performance in the area of physical health interface during SFY 04 for adoption in SFY 05.**

Comments of the Mental Health Services Planning Council

In relation to the first three objectives regarding deaf and hard of hearing initiatives, one Council member stated that he believed that Medicaid should be interested in the development of a support system for individuals with mental illness and who are deaf and hard of hearing. He stated that one individual placed out-of-state into an appropriate specialized inpatient setting would be enough to support the development of an equivalent, community based alternative in Kentucky.

Staff within the Deaf and Hard of Hearing office will explore this issue with the Department for Medicaid Services.

One Council member suggested that individuals need to be hired who can provide services for Spanish speaking individuals with mental illness; another suggested recruiting bilingual individuals straight out of high schools.

Staff agree that services for Spanish speakers need to be developed, especially in those parts of the state where census figures show increasing numbers.

One Council member lauded the effort to train consumers to be leaders, and suggested that his agency (Protection & Advocacy) might be able to contribute some funds to this effort.

Staff welcome this offer to pool funds.

In commenting on A-1-5, one Council member suggested that program reviews are usually better received when conducted by peers, as opposed to Central Office staff.

It was explained that this was a factor in the redesign of the Peer-to-Peer Review process and that Central Office staff would only be providing logistical support.

One consumer Council member asked whether Region One had a policy about hiring consumers ?

Staff responded that they did not know the answer to the question.

One Council member who represents family members stated that she thought the Regional Planning Council members should be involved in HB 843 meetings in their regions. She expressed her opinion that it's not like you're really involved in the meeting.

Staff encouraged her and others to be involved in the Leadership Training Academy so individuals could return to their Regions, serve on Boards and advocate for change with a strong voice.

In relation to Objective A-1-9, a Council member stated that Protection & Advocacy monitors crisis stabilization programs and wondered how the Department monitors "non-residential" programs.

Staff stated that we look at the original proposal and "flow chart" for how clients move through the system once they are identified to be in crisis. It was pointed out that data collection was more difficult given the number of different services that may be provided in a non-residential program.

In relation to Objective A-1-10, one parent of a child with SED recounted her experience with a state hospital that encouraged her daughter to be discharged to a homeless shelter rather than return home.

Staff described the effort to improve continuity of care between state hospitals and homeless service providers, as well as the tracking of individuals discharged to shelters.

In relation to Objective A-1-13, several Council members spoke out about their experience with Therapeutic Rehabilitation programs operated by the Regional MH/MR Boards. One Council member stated that her daughter has done great in a TRP in Paintsville. Another member stated that he thought they were mixed – either very good or very bad (quality). Another member stated that skills training was the answer to improving the programs. In relation to employment, another Council member cited the lack of involvement by the vocational rehabilitation system. A consumer Council member related her experience as a TRP client and her unsuccessful efforts to obtain employment services through the vocational

rehabilitation system. A summary comment was made that the goal for therapeutic rehabilitation programs should be to put themselves out of business – to assist people to live, work and recreate in the community on their own.

Staff reaffirmed the point of this goal – to adopt the use of psychiatric rehabilitation principles as the standard while moving toward employment, housing, education and satisfying relationships.

In relation to Objective A-1-14, a Council member stated that if Kentucky could adopt the Medicaid Buy-In many consumers in therapeutic rehabilitation programs could become employed. Another member reminded the group that the elderly (55-85) may not be appropriate for employment and to not forget their needs. Another member stated that even the elderly could work (like people in Walmart).

Staff relayed the Cabinet's position that the Medicaid Buy-In could not currently be supported (due to the state's fiscal crisis).

In relation to the three housing objectives, A-1-15 through A-1-17, the Protection & Advocacy representative stated that they would be conducting open forums in four CMHC operated housing complexes to monitor for rights violations and coercive practices.

Staff stated that the Division has continually reminded housing providers of the basic principle of Supported Housing, that receipt of services should be separate from maintaining one's housing.